Chapter 1
CON Study Overview

Introduction

During its 1999 session, the Maryland General Assembly passed House Bill (HB) 995, entitled Health Care Regulatory Reform-Commission Consolidation (Chapter 702 Annotated Code of Maryland). Under this legislation, the duties and responsibilities of the Health Care Access and Cost Commission and the Health Resources Planning Commission were consolidated and streamlined under the Maryland Health Care Commission. The uncodified language in Section 11 of HB 995, as enacted, requires the Maryland Health Care Commission to develop priorities, a work plan, and a process for reviewing major policy issues related to the certificate of need (CON) process during calendar years 2000 and 2001. To address this requirement of HB 995, the Commission submitted a report to the General Assembly on January 1, 2000 providing a detailed work plan for examining the CON process in Maryland.[6]

The CON study work plan submitted to the General Assembly outlined specific services for in-depth study over the two-year period, 2000-2001. During the initial year of the study, the following priorities were established:

Acute and Ambulatory Care Services
- Cardiac Surgery Services
- Acute Inpatient Obstetric Services

Long Term Care, Mental Health and Other Services
- Home Health Services
- Hospice Services
- Comprehensive Care (Nursing Home) Services

During calendar year 2001, the Commission's study will consider the remaining health care services regulated under Certificate of Need requirements, including:

Acute and Ambulatory Care Services
- Specialized hospital services (including NICU, organ transplant surgery, burn treatment, and comprehensive inpatient rehabilitation services)
- General hospital services (including pediatrics and acute psychiatry)
- Ambulatory surgical services

Long Term Care, Mental Health, and Other Services
- Residential treatment centers
- Mental health and substance abuse services
- Other services (ICF/MR)

[6] Maryland Health Care Commission, *Reports Required Under Section 11 of House Bill 995 (1999)-Health Care Regulatory Reform-Commission Consolidation*, Part II, Work Plan for Examining the Certificate of Need Process: Preliminary Report, January 1, 2000.

During the first phase of this two-year study, a series of working papers were released to address the individual services prioritized for review. Each of those working papers provided background information on the service, discussed current mechanisms for government oversight of the service in Maryland, and outlined a series of alternative regulatory options for government oversight of market entry and exit. For cardiac surgery, home health, hospice, and comprehensive care services, the working papers included information on the functioning of other state CON programs in regulating the service. This series of working papers was released according to the following schedule:

Service	Date of Release
Acute Inpatient Obstetric Services	7/21/00
Cardiac Surgery Services	8/18/00
Home Health & Hospice Services	9/15/00
Nursing Home Services	10/25/00

Following release of the working papers, the Commission sought public comment on the regulatory options for oversight of market entry and exit. The Commission also sought public comment prior to finalizing the recommendations to the General Assembly that are included in this Phase I report. (The Appendix to the report provides a list of the organizations participating in this study of the Certificate of Need program.)

Maryland Certificate of Need Program: Background

The Maryland Certificate of Need (CON) program is designed to ensure that new health care services and facilities are developed only as needed, based on the publicly-developed measures of cost effectiveness, quality of care, and geographic and financial access to care. CON review of proposed projects implements the policy goals and service-specific standards articulated in the State Health Plan, and allows the Commission to oversee, monitor, and respond to the effects of changes in the system influenced by the marketplace. This public participation enables the Commission to determine whether proposed health care projects address the community's health care priorities and are in the public interest. More specifically, the CON program is intended to:

- **Protect against overbuilding**, particularly in services based in facilities;
- **Protect against over-utilization**, which could be generated by excessive supply of a service and profit motive of providers competing for finite number of patients;
- **Protect the Medicaid budget, and other public funds**, where they become a prime source of reimbursement (such as with nursing homes, where nearly 70% of residents are paid for by Medicaid by the end of their first year in a facility);
- **Ensure a rational, planned growth in capacity**, tied to population, demographics, and changes in medical practice and technology, through policies, standards, and statistical projections of need adopted as part of the State Health Plan;
- **Limit the number of programs providing some highly-specialized services, where a sufficient number of cases or procedures is crucial to guaranteeing good quality and outcomes of care;**
- **Ensure access to needed health care services** by promoting the development of capacity in appropriate geographic areas and discouraging growth in areas already adequately served;
- **Guarantee public notice of and participation in decisions affecting its health care delivery and availability** through local health planning, public notice, public informational hearings;
- **Guarantee legal due process** in contested reviews for new services, where there are many applicants for a limited projected need; and
- **Foster competition among these applicants**, encouraging improvements and greater cost-effectiveness in proposed service, to help ensure that "best" provider wins, and citizens receive even higher quality and availability of care than they would without that competition.

Coverage by Certificate of Need Review

With certain key exceptions to each requirement set forth under applicable sections of statute, **a Certificate of Need is required:**

- **"Before a new health care facility is built, developed, or established";**

For purposes of CON review, "health care facility" includes:

- Acute general hospitals
- Specified acute care services: obstetrics, pediatrics, and acute psychiatry
- Special hospitals: chronic, psychiatric, rehabilitation, pediatric
- Ambulatory surgical facilities (defined as having two or more operating rooms)
- Comprehensive care facilities (nursing homes, or "related institutions" in statute)
- Residential treatment centers for seriously emotionally ill children, adolescents
- Intermediate care facilities-mental retardation services
- Intermediate care facilities-substance abuse treatment services
- Freestanding and hospital-based ambulatory surgical facilities
- Home health agencies
- Hospice services (including providers in inpatient settings)
- Cardiac surgery and therapeutic catheterization services
- Burn treatment centers
- Organ transplant surgery
- Neonatal intensive care services

However, CON is <u>not</u> required to:

- Close a hospital or medical service provided by a hospital.
  - The closing of a hospital is explicitly not required to obtain Certificate of Need review and approval; CON review has not been required to close a hospital in Maryland since 1985.
  - HB 994 (1999) further streamlined the closure of a hospital or a medical service at a hospital in counties with three or more hospitals, which since October 1999 requires only a 45-day notice to the Commission, and the holding by the hospital or health system of a public informational hearing in the affected community.
  - The law still requires the Commission to make a finding via the CON exemption process for proposed closures of hospitals or hospital services in counties with one or two hospitals.
- Establish any of the following:
  - An assisted living facility;
  - A "freestanding ambulatory care facility," including, for State licensure purposes, freestanding endoscopy facilities, facilities for the use of major medical equipment[7],

[7] Deregulated in Maryland from CON review in 1985, major medical equipment is still subject to CON review and approval in many states.

kidney dialysis centers, and freestanding birthing centers.

- **"Before an existing or previously approved, but unbuilt, health care facility is moved to another site";**

However, CON is <u>not</u> required to:

- Replace all or part of a service at a hospital or related institution on the same or an "immediately adjacent" site, or
- Relocate an existing health care facility, for a merged asset hospital system under specified circumstances.

- **"Before the bed capacity of a health care facility is changed";**

However, CON is <u>not</u> required to:

- Exercise the so-called "creep" or waiver bed rule, and increase or decrease beds equivalent to 10% of capacity or ten beds, whichever is less;
- Change the number of beds allocated to each approved medical service at a hospital, if the total licensed capacity remains the same;
- Increase or decrease bed capacity if proposed pursuant to a merger or consolidation between any category of inpatient health care facilities;
- Increase or decrease the number of beds between hospitals in merged asset systems in counties with three or more hospitals in the same health service area, with 45-day notice to the Commission.

- **"Before the type or scope of any health care service is changed, if the health care service is offered by a health care facility";**

This section of Commission statute explicitly requires CON approval to establish a new medical service, or eliminate an existing service (except at hospitals);

However, CON is <u>not</u> required to:

- Convert an existing hospital to a limited service hospital, with no inpatient admission capacity and a twenty-four hours a day, seven days a week emergency department.
- Reconfigure or relocate existing medical services between members of a merged system.

- **"Before [any of the specified] capital expenditures are made by or on behalf of a health care facility."**

This section of Commission statute explicitly requires CON approval for expenditures by health care facilities over the statutory threshold for capital review as adjusted for inflation – currently $1.45 million.

However, CON is <u>not</u> required:

- For expenditure of capital to acquire an existing health care facility, if the Commission receives notice at least 30 days before the sale is concluded, and neither services nor capacity are changed as a result of the acquisition;
- For a capital project over the review threshold proposed by a hospital, if the Health Services Cost Review Commission notifies MHCC that the hospital's financial projections support "the pledge" not to seek a rate

increase related to the capital expenditure greater than $1.5 million over the life of the project.

●General Certificate of Need Review Criteria

Applications to the Commission for Certificate of Need review are not only measured against the appropriate State Health Plan policies, standards and need projections for the health care service involved, but also evaluated according to six general review criteria, found in the CON procedural regulations at COMAR 10.24.01.08G(3). Applicants for CON approval by the Commission must demonstrate:

- That a proposed project **meets "all relevant State Health Plan standards, policies, and criteria"**;

- That proposed **new facilities or services are needed**, according either to a statistical need projection adopted by the Commission, or as demonstrated by a quantitative analysis of need provided by the applicant, which documents an "unmet needs of the population to be served," and supports the ability of the proposed project to meet those needs;

- That the proposed project represents **a more cost-effective means of providing a proposed service**, as compared to existing facilities or health care providers, or as compared to competing applicants for the same service in a comparative review;

- That proposed new facilities or services they propose are viable, because **both the financial and the "non-financial" resources – such as community support and appropriate levels of needed professional and support staff -- are available** at a level sufficient to implement the project within the prescribed time frames, and to sustain the facility or service once established;

- That the applicant or existing health care provider has met all of **the conditions applied to previous Certificates of Need**, and any commitments made that resulted in a preference in a previous CON review, if applicable; and

- That the proposed new facility or service will not have an unduly negative **impact on existing providers of the health care service in the same service area**, including the potential impact on "geographic and demographic access to services, on occupancy where there is a risk that [a new provider] will increase costs to the health care delivery system, and on the costs and charges of other providers."

Certificate of Need review in Maryland evaluates each proposed project according to this body of general criteria that apply to all reviews and all services, as well as the specific set of State Health Plan policies, standards, and need projections that apply to the category of health care service under consideration.

●Levels of Certificate of Need Review

Functionally, the CON program consists of three levels of review, two of which proceed from a determination – based on

policies and precedents articulated by statute, CON procedural rules, the State Health Plan, and a considerable body of administrative history – that for a certain kind of proposed action by a health care facility or provider, Certificate of Need review is not required. Table 1-1 illustrates the functional and procedural distinctions between these three levels of review.

Table 1-1
Description of the Levels of Review:
Maryland Certificate of Need Program

Level of Review	Initiated By	Decision By	Contested or Appealed By	Time Frame
Determination of Non-Coverage of Certificate of Need Review	Letter Requesting Determination of Coverage (COMAR 10.24.01.14B)	Executive Director	No	30 Days
Exemption from Certificate of Need Review	Notice of Intent to Seek Exemption from CON Review (COMAR 10.24.01.04)	Commission -With staff review & recommendation	No (Public comment permitted, but no party formally qualified to object)	45 Days
Certificate of Need Review	Letter of Intent followed 60 Days later by CON application (According to scheduled review or initiated by the applicant)	Commission -With staff recommendation if uncontested - Recommendation By Commissioner Reviewer if contested and/or comparative	Yes Adversely affected parties may seek to qualify as interested parties under definitions in regulations, with right to: (1) request oral argument or evidentiary hearing (2) submit written exceptions to recommended decision and argue before Commission; (3)request reconsideration of decision; and (4)appeal adverse decision in circuit court.	90 Days (150 Days if an evidentiary hearing is held)

Each category of project review within the Commission's authority to operate the Certificate of Need program begins in essentially the same way: a person or an existing health care provider writes to the Commission either to seek its determination as to whether CON review and approval is required to undertake a proposed project, or to provide notice of the intent to seek Certificate of Need or exemption from Certificate of Need. In cases where a request for determination of CON coverage

involves an analysis and interpretation of existing law and regulation, Staff and counsel research and prepare a response, which is issued by the Executive Director as the Commission's designee.

Since 1985, the health planning statute has provided for the second level of CON review, the authority of the Commission to find, "in its sole discretion," that some actions otherwise covered by CON requirements, if undertaken by specific kinds of health care facilities do not require Certificate of Need review and approval. The exemption from CON review came into the law as a procedural incentive for hospitals to merge and consolidate, or close, and was enacted in response to the problem of excess hospital bed capacity.

The statutory requirement that a health care facility obtain CON approval from the Commission to close – still in effect for other kinds of health care facilities and services – was intended to ensure that the public would receive notice of any proposal to remove health care services from a community, and that a public body would closely scrutinize the impact of that closure on access to care. Removing that requirement -- permitting the Commission to find that no CON was required, if a proposed hospital closure (or merger and consolidation of services) was "not inconsistent with" the State Health Plan, would result in the more efficient and effective delivery of health care services, and was in the public interest – provided a clear policy direction that the voluntary closure of unneeded hospital capacity was (and is) an important State policy goal.[8] HB 994 extended the exemption finding to additional actions by hospitals and merged-asset hospital systems, to provide the same kind of procedural incentive.

As described in Section C. below, the percentage of these two non-CON levels of CON review, as compared to the projects that do require full CON review, has increased significantly over the past three years. This shift away from the review and approval of new capacity through Certificate of Need, to emphasize the reconfiguration and relocation of existing services – considered and acted upon after an expedited and uncontested review – accurately reflects the further changes in the health care environment during that same period.

Evolution of Certificate of Need in Maryland

In Maryland, the history of Certificate of Need has been a dynamic one. Responding to the many changes shaping the system of health care delivery and financing nationally -- from the advances in medical technology to the growth in managed care as a means of structuring and allocating payment – the legislature responded to the industry, to groups of assembled experts like the Governor's Task Force on Health Care Cost Containment in 1984, and continually added to or changed what services and actions by

[8] In the fifteen-year history of the exemption provision, seven Maryland hospitals have closed: Homewood-South (formerly Wyman Park), Homewood-North (formerly North Charles General), Leland Memorial, Frostburg, Liberty Medical Center, Children's, and Church Hospital. Church Hospital was closed in October 1999 under the then newly-effective provision of HB 994, permitting hospitals to close in jurisdictions with three or more hospitals with only a 45-day notice to the Commission, after a public hearing is held in the affected community.

health care facilities would require CON approval.

Most of the changes to CON in Maryland from 1984 through this past legislative session, as illustrated in Figure 1-1, were changes in coverage – in what actions by existing or proposed new health care facilities require CON review. In 1985, the first significant procedural change was made, to enable some important changes in coverage: recommendations by the Governor's cost containment task force brought into statute the Commission's authority to exempt certain actions by hospitals and systems of merged facilities from CON review, if it found after an expedited review that the proposed action "is not inconsistent with the State Health Plan, will result in the more efficient and effective delivery of health services, and is in the public interest." The authority to exempt from full CON review a proposed hospital closure, or relocations of beds or services between facilities owned or controlled by the same entity, was intended to encourage the voluntary downsizing of the hospital system, by the institutions themselves, with an important procedural incentive.

Not until 1995, however, was the first truly comprehensive reform of the CON review procedure undertaken. The extensive federal requirements for the CON review process – full Administrative Procedure Act evidentiary hearings, with interested party rights vested in a broad spectrum of regional health systems agencies, local governments, and virtually anyone who claimed to be affected by a proposed new facility or service – had been repealed in late 1986. Although Maryland had enacted its own CON requirement in the knowledge that the federal mandate would soon end, it took almost ten years to recognize that the important values of public participation and due process could be served by a less time-consuming, less costly procedure.

Guided by advice from the Attorney General's office on the minimum level of due process protection required for contested cases, the former HRPC proposed a comprehensive re-design of the CON review process, which was included in SB 639, the Health Care Reform Act of 1995. The major procedural changes the provisions of SB 639 made to the CON review procedure included the following:

- The statutory time limits for CON review went from 120 days from docketing, for reviews in which no evidentiary hearing was held, to 90 days; in reviews with evidentiary hearings, the review period remains at 150 days -- but the other major change in the law limited the right to request a full evidentiary hearing to the largest, most complex and costly projects.[9]

- The new law reduced the time in which staff must review applications for "completeness," or the presence of all information necessary to place the matter on the official docket and begin the 90-day clock, from fifteen to ten working days.

[9] To date, since 1995 no evidentiary hearings have been held in contested CON reviews. The Commission has held two limited evidentiary hearings, in its successful actions to withdraw two long-unbuilt nursing home CONs.

- The new law narrowed the definition of "interested party," of who may enter a review in opposition to a proposed project, and, if "aggrieved" by the Commission's decision, ask it to reconsider, or bring a judicial appeal. Beyond the Commission's staff and competing applicants, only persons who can demonstrate "adverse impact" from an approved new health care facility or service could now enter a review as a legally-empowered interested party.

CON review could now essentially be a review of the entire written record of a case, with the Commission authorized to appoint one of its members to act as the Reviewer of one or more applications, in the case of a contested review. The Reviewer examines a staff analysis, the applications and other written submissions in a case, and facts established in any oral argument, and recommends a decision to the full Commission. In uncontested reviews, staff brings an analysis and recommendation directly to the Commission for its action. Aggrieved parties could still request Commission reconsideration of a decision, or take an immediate judicial appeal.

The primary result of these streamlining changes in CON review was a dramatic initial increase in the number of pending CON reviews completed and brought to the Commission for action, and an equally dramatic decrease in the average time per decision.

Performance of the Maryland CON Program

Over the past three fiscal years, 1998 through the end of FY 2000, the Maryland CON program has continued its evolution, reflecting the shifts in the market caused by external forces such as changes in federal reimbursement policies, the increasing presence of managed care, and continuing advances in medical techniques and technologies.

Figure 1-2 illustrates the increase in determinations of non-coverage by CON review requirements, as measured against the number of full Certificate of Need and CON exemption reviews. Although many of the proposals brought to the Commission for a determination of CON coverage present complex legal and policy questions, CON procedural rules require that determinations of coverage be issued within thirty days of receipt of the written request. The increase in these requests for coverage determination is another indicator of the challenges facing health care facilities and service providers, as they search for the most cost-effective ways to cope with often seismic shifts in occupancy, payment, and the available work force, while struggling to maintain a high quality of care.

Figure 1 - 1

Evolution of the Certificate of Need Program: 1984 to the Present

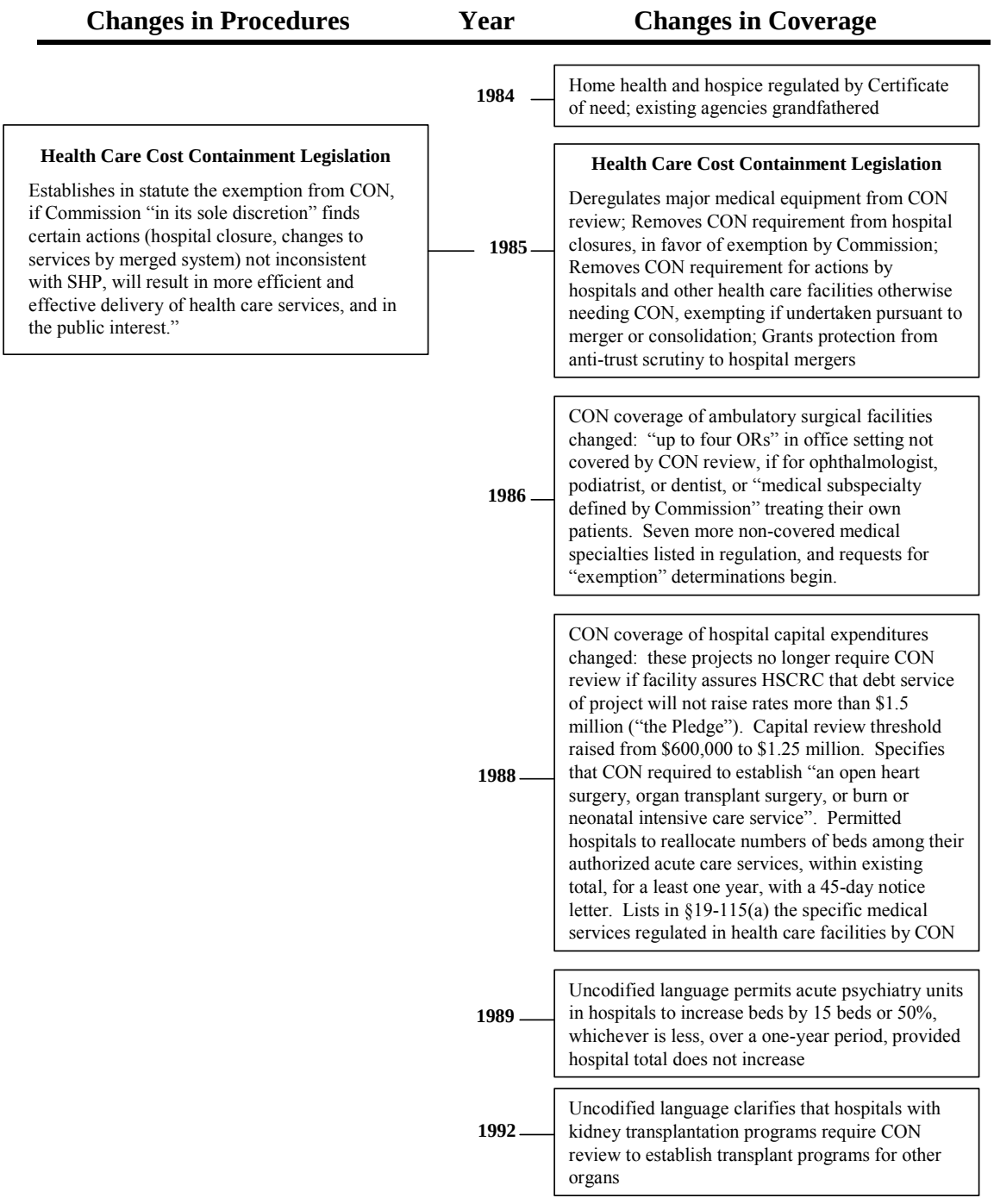


Figure 1 – 1 (Continued)
Evolution of the Certificate of Need Program: 1984 to the Present

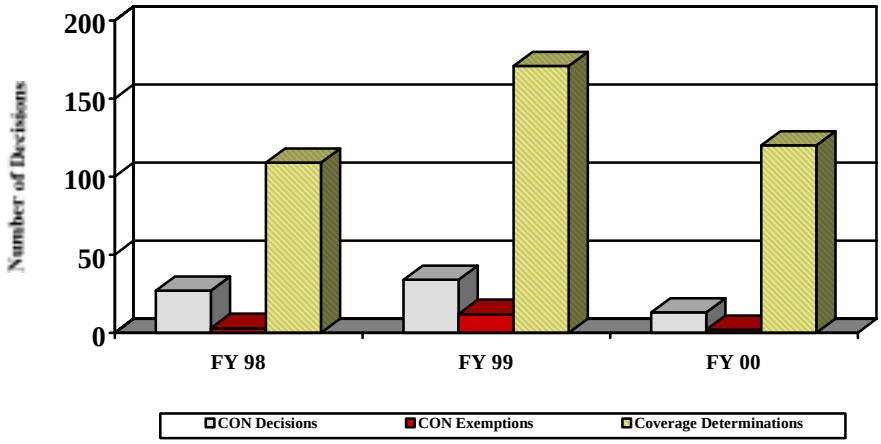
Changes in Procedures	Year	Changes in Coverage
Health Care Reform Act of 1995: Major changes designed to streamline review process; Normal review is of the written record, with Commissioner appointed to recommend decision to Commission in contested cases; Evidentiary hearing only in cases where "magnitude of impact" of proposed facility or service warrants; Definition of who may be (legally-) interested party narrowed, limiting parties who may appeal; statutory time frames for review reduced from 120 to 90 days where no evidentiary hearing held, remain 150 if an evidentiary hearing held[5]	**1995**	**Health Care Reform Act of 1995:** Reference to medical specialty removed from statute as factor in determining CON coverage of proposed ambulatory surgical capacity: office or facility with two or more operating rooms requires CON review, while single OR can obtain non-coverage letter . Uncodified language establishes grandfathering rules for proposed FASFs with non-coverage letters, and recognizes existing, operating.
	1996	Clarification enacted to SB 639 provisions, to permit hospitals to acquire existing CON-approved, CON-exempt, or non-covered one-OR entities without additional CON review.
	1998	Relocation of approved-but-unbuilt CON projects required to obtain CON
	1999	**HB 995 merges HCACC and HRPC** HB 994, Hospital Cost Containment and Capacity Act passed: Hospitals in counties with 3+hospitals permitted to close with 45-day notice, public hearing. Hospitals in merged asset systems may relocate beds between its facilities in same HSA with 45-day notice letter. Hospitals in merged asset systems may relocate facilities with either 45-day notice letter (if in primary service area of facility) or CON exemption (in PSA of system). "Spousal carve-out" provision permits direct admission into CCRC nursing home of one of two subscribers in "significant long-term relationship"
	2000	Percentage of CON-excluded beds at CCRC nursing home raised from 20% to 24%; Direct admission to CCRC nursing home permitted within limits set forth in statute, which sunset in two years

Source: Maryland Health Care Commission

[5]Since 1995, the only evidentiary hearings held were in two reviews that had begun under the old rules, and two brief and focused hearings required in two actions for withdrawal of non-performing CONs

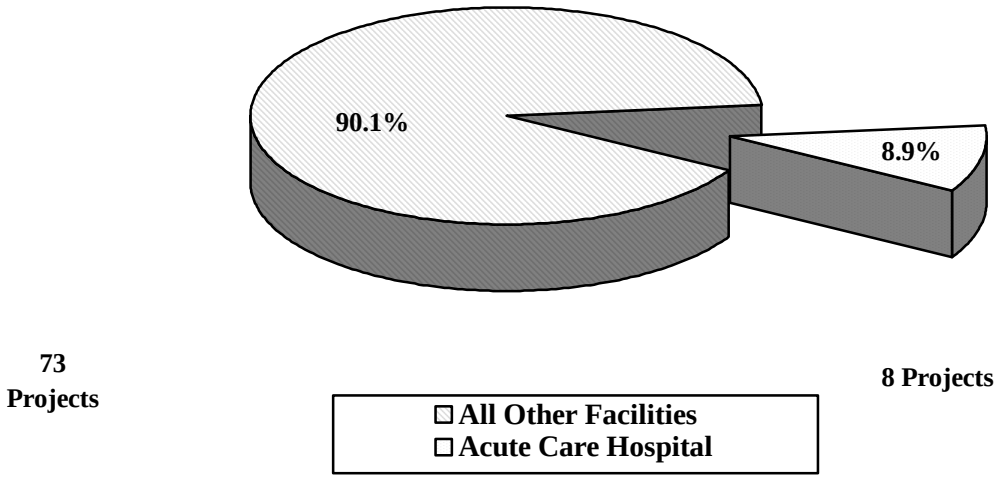
Figure1-2
Categories of Certificate of Need

Decisions:
Maryland, FY 1998-2000



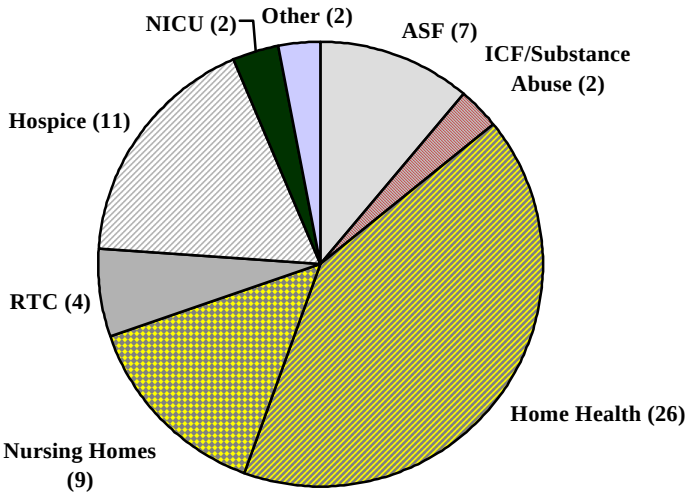
Another trend that continues to shape the agenda and work of the Maryland CON program actually began in the late 1980s, with the series of statutory measures granting a high degree of flexibility to the hospital industry. The 1985 CON exemption for service changes undertaken "pursuant to a merger or consolidation," and for closures of medical services and entire facilities, marked the first in a series of changes to procedural rules relating to hospital projects. In 1988, hospitals gained the ability to reallocate beds dedicated to existing acute care services within the total licensed capacity, as well as "the pledge" that removed CON review from virtually all hospital capital projects over the last twelve years. Additional measures were enacted, including the changes made by HB 994 in the ability of hospitals -- particularly those in the four jurisdictions with three or more hospitals, and those hospitals in merged asset systems – to place many actions they undertake outside of the CON review or exemption process.

Figure 1-3
Percent of Total Certificate of Need Decisions Related to Acute Care Hospitals: Maryland, FY 98-00



The experience of the last three years, as shown in Figure 1-3 above, has simply continued the shift in the Commission's CON work agenda since 1985, away from matters involving acute general hospitals, in favor of the others sectors of health care. Figure 3 illustrates what, for the past three years, have been the kinds of services and projects that have received CON approval from the Commission. Under each of the separate studies of health care services and facilities regulated by the Commission through CON review, Staff will describe the changes over time in the number of nature of CON actions in that service. Tracing the changes over the years in what has come to the Commission for CON review also traces the history of the successive federal payment reform initiatives, as well as the shift across all services from institutional to ambulatory, community-based settings, which were happening at the same time.

Figure 1-4
Certificate of Need Approvals by Type of Activity or Health Care Facility: Maryland, FY 98-00



Total Projects = 63

Source: Maryland Health Care Commission

Maryland Certificate of Need Program Compared with Other States

Thirty-six states, as shown in the latest national directory published by the American Health Planning Association, have Certificate of Need review for some number of health care services and proposed expansion of capacity. Maryland ranks in the lower third of what the AHPA calls its "Relative Scope and Reviewability" ranking (Table 1-2) which lists the CON states in descending order, beginning with those with the most covered services and lowest capital and service review thresholds.

Fourteen states no longer have a CON program, and studies similar to that mandated by Maryland's HB 995 have re-evaluated and changed CON programs in many more states over the last four to five years. The Staff working papers for each specific CON-regulated service will review in more detail the situation across the country with regard to CON coverage – and alternative administrative tools – with which each service is regulated in other states. In general, however, the CON states have been most reluctant to deregulate nursing home services; even in the Western states, which shut down their programs in some cases even before the federal repeal, the Medical Assistance agency must review and approve any new nursing home that will seek Medicaid reimbursement. Numerous states have simply imposed a moratorium on nursing home beds and projects, in order to limit the growth of their Medicaid budgets and

Table 1-2
COMPARISON OF NUMBER AND SCOPE OF HEALTH CARE FACILITIES & SERVICES COVERED IN STATES WITH CON PROGRAMS

RANK[6]	STATE[7]	Acute Care	Air Ambulance	Amb Surg Ctrs	Burn Care	Business Cmptrs	Cardiac Cath.	CT Scanners	Gamma Knives	Home Health	ICF/MR	Lithotripsy	Long Term Care	Med Off Bldg	Mobile HiTech	MRI Scans	Neo-ntl Int Care	Obstetric Svcs	Open Heart Svcs	Organ Transplant	PET Scans	Psychiatric Svcs	Rad Therapy	Rehab	Renal Dialysis	Res Care Fac	Subacute	Substance Abuse	Swing Beds	Ultrasound	Capital Threshold	Other Services[8]
31.2	ME	X	X	X	X		X	X	X		X	X	X		X	X	X	X	X	X	X	X	X	X	X			X	X	X	X	
30.8	WV	X		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		X	X	X	X	X
27.6	GA	X		X	X		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X				X			X	X
27.5	CT	X	X	X	X	X	X	X	X		X	X	X		X	X	X	X	X	X	X	X	X	X				X	X	X	X	X
27.0	AK	X	X	X	X		X	X	X	X		X	X		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
22.5	VT	X	X	X	X	X	X	X	X	X	X	X	X		X	X	X	X	X	X	X	X	X	X				X	X		X	
21.0	MO	X		X			X		X		X	X	X		X	X	X	X	X		X	X	X	X	X	X	X	X			X	X
20.9	SC	X		X			X		X	X	X	X	X		X	X	X	X	X		X	X	X	X			X	X			X	
19.8	MS	X		X			X		X	X	X	X	X			X			X		X	X	X	X	X	X		X	X		X	
18.4	NC	X	X	X	X		X	X	X	X	X	X	X		X	X	X		X	X	X	X	X	X	X			X			X	X
18.4	IL	X		X	X		X		X		X	X	X	X			X	X	X	X	X	X	X	X	X	X	X	X	X		X	X
17.1	NJ	X			X		X		X	X	X	X	X		X		X	X	X	X	X	X	X	X		X		X			X	
16.2	KY	X		X			X			X	X		X		X	X	X		X	X		X	X	X		X	X	X			X	X
16.1	DC	X		X			X	X	X	X		X	X	X	X	X	X	X	X	X	X	X	X	X	X		X	X	X		X	
15.3	**MD**	**X**		**X**	**X**		**X**			**X**	**X**		**X**				**X**	**X**	**X**	**X**		**X**		**X**			**X**	**X**	**X**		**X**	**X**
15.2	MI	X	X	X			X	X	X			X	X		X	X	X		X	X	X	X	X		X			X			X	X
15.2	RI	X		X			X	X	X				X		X	X	X	X	X	X	X	X	X	X			X	X	X		X	
15.0	HI	X	X	X	X		X	X	X	X	X	X	X		X	X	X	X	X	X	X	X	X	X	X		X	X	X		X	
13.6	TN	X		X			X	X		X	X	X	X			X	X				X	X	X	X			X	X			X	X
13.2	NY	X		X	X		X	X	X	X	X	X	X		X	X	X		X	X		X	X	X	X			X	X	X	X	
12.6	WA	X		X	X					X			X				X	X	X	X				X	X		X		X		X	X
12.0	AL	X		X			X		X	X		X	X			X	X	X	X	X	X	X	X	X	X			X	X		X	X
11.7	NH	X		X			X	X				X	X		X	X			X			X	X	X				X			X	
8.4	AR									X	X		X													X	X		X		X	X
8.4	FL	X			X					X	X		X				X		X	X		X					X	X				X
8.1	IA			X			X				X		X						X	X	X		X								X	X
8.0	VA	X		X			X	X	X		X	X	X		X	X	X	X	X	X	X	X	X	X				X			X	X
7.0	OK										X		X									X						X			X	X
6.3	MT			X						X	X		X											X				X	X		X	
5.1	MA		X	X					X			X	X			X	X		X	X	X	X	X	X		X		X		X	X	X
4.9	NV	X		X							X		X											X			X	X			X	
4.8	DE	X		X			X					X	X								X		X								X	X
4.4	WI										X		X														X				X	X
1.0	OH												X																		X	X
0.6	OR												X																X		**	
0.6	NE												X											X							**	
0.4	LA										X		X																			

This chart is adapted from the American Health Planning Association's annual graphic, last updated in AHPA's 2000 Directory of Health Planning Policy & Regulatory Agencies (11th ed.), which compares the "National Relative Scope and Reviewability Threshold of CON Regulated Services" among the states. The 2000 version of AHPA's graphic contained some errors with regard to Maryland's services, which have been corrected in Staff's adaptation. Consequently, the "severity" index as calculated according to several factors, including number of services regulated and level of capital review threshold, may not precisely reflect Maryland's "weight" or "severity" according to AHPA's formula, compared to other CON states. However, the chart's relative position of Maryland's CON program--which does not cover a significant number of health care facilities and services regulated by many other states--would still be in the middle range of CON programs, nationwide.

** Any capital expenditure for LTC

[6] No. of services x weight as determined by the Missouri CON Program
[7] Including the District of Columbia
[8] Services in addition to those most often CON-regulated.

because falling nursing home occupancies are a nationwide phenomenon.

Guiding Principles of the Certificate of Need Study

Maryland has been and continues to be an active and innovative State in developing health policy initiatives. To develop a consensus around a set of principles by which to evaluate and potentially change a regulatory tool for a diverse group of health care services requires that every stakeholder in the study's outcome consider, and answer some fundamental questions. The responses of providers, payers, and consumers of State-regulated health care services to these questions will help to shape the guiding principles and recommendations on the future of CON in Maryland.

Need

- What is the role of State government oversight in structuring the supply and distribution of certain health resources?

- What is the role of State government oversight in regulating market entry and exit?

- What are the appropriate geographic regions for planning and regulating hospital services? Nursing home services? Highly specialized services?

Access

- As the health care system continues to downsize and consolidate, what is the role of CON in ensuring access to care?

- For services where market and referral areas cross state boundaries, how should regulatory policies and decisions be coordinated with adjacent states?

Cost Containment

- Should providers that offer benefit to special populations be given an advantage or protected by the State regulatory system?

- What is the role of CON in promoting competition?

- How should the incentives and goals of the CON program be aligned with the hospital rate setting program? With the Medicaid program? With other health policy initiatives?

Quality of Care

- What is the role of CON in establishing and monitoring compliance with quality and outcome standards?

- What is the role of CON in staffing standards?

Accountability

- What is the role of State government in monitoring the performance of health care facilities and services?

- What role does CON play in ensuring public awareness and participation in decisions that affect delivery of and access to health care services